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Olakivi, Antero Olavi

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### **Early-career doctors and in/justice in work: The invisibility of gender in a ‘male’ profession**

Antero Olakivi\*, PhD, Researcher, ORCID ID 0000-0002-7011-8536

Sirpa Wrede\*, Docent, University Lecturer, ORCID ID 0000-0001-7358-2097

\*University of Helsinki, Faculty of Social Sciences

#### **Abstract**

This chapter examines medical doctors’ ways of constructing and mitigating gendered and age-related injustice in their work and careers. Interviews with doctors at different career stages and in different professional settings in Finland are analysed. The analysis demonstrates that the interviewed doctors were not eager to construct the gendered and age-related constraints they or their colleagues face at work as markers of illegitimate inequality. The doctors were more eager to view work-related constraints as the result of personal choices and emphasise doctors’ private responsibility to manage their work and careers. In this chapter, we contextualise these observations as features of the ‘male’ profession of medicine and the profession’s emphasis on middle-class masculinity, which, despite the growing proportion of female physicians in younger cohorts, dominates over other career and work orientations in the culture of the Finnish medical field. The culture of male professions values individual endurance and freedom from family responsibilities, which may have problematic consequences for young doctors, particularly young mothers, whose childcare responsibilities can

disproportionately limit their opportunities to perform the expected, normative, middle-class and masculine impressions of themselves as completely devoted to their work.

## **Introduction**

In 2016, we interviewed 38 doctors at different career stages and in different professional settings in Finland for a study that targeted, among other things, the issue of clinical autonomy (Wrede et al. 2017).<sup>1</sup> When listening to the doctors from a gender perspective, we were somewhat surprised; despite the salient gendered divisions of labour in the Finnish medical field, the interviewed doctors seemed to almost avoid talking about the relevance of gender in their work and careers. To make sense of the invisibility of gender in our interview data, we turned to research on the ‘gendering’ of organisations. Rather than considering the superficial ‘gender neutrality’ of our co-constructed interviews to indicate the irrelevance of gender in the medical field, we assumed that all organisations constantly shape gendered inequalities and divisions of labour through policies, practices, culture and interactions (eg Acker 1990).

In line with critical studies of work organisation, we assume that, despite the growing proportion of female physicians in younger cohorts, middle-class masculinity continues to dominate over other career and work orientations in Finnish medical culture (also, Davies 1996). This culture of ‘male’ profession, we argue, values freedom from family responsibilities and thus may have problematic consequences for young doctors, particularly young mothers, whose childcare responsibilities can disproportionately limit their opportunities to perform the expected, normative, middle-class and masculine impressions of themselves as completely devoted to their work. In the context of a numerically ‘feminised’ profession, we argue that, by not problematising the organisation of work from a gender perspective, doctors can (sometimes tacitly and unwittingly) reproduce the masculinised career context of their profession.

In the following section, we discuss gendered and age-related inequalities within the Finnish medical profession that are expressed in related patterns of segregation within the profession and doctors' reports about work-related concerns and challenges. We then elaborate upon our theoretical position, drawing on the interactionist line of thought in the sociology of professions (see Riska 2010). From this perspective, we claim that, while masculine expectations dominate within the culture of the medical profession, the *legitimacy* of the gendered and age-related structures within the profession is an interactional accomplishment and must be constantly negotiated and updated in discursive practice.

Our empirical analysis is presented with two slightly different foci associated with gendered and age-related inequalities in the organisation of work. First, we examine the issue of on-call shifts, which are common at hospitals. Through commitment on-call work, we argue, doctors can perform the 'right' kind of career orientation, the absence of which appears to be a legitimate excuse for non-advancement. Second, we analyse public health centres as a constraining work context, considering the problematic position of young doctors facing stressful and lonesome work and the cultural ideals that highlight individual and masculine endurance in health centres. These two foci are united by their relevance to young female doctors. In Finland, young (ie under 35 years of age) and female doctors are overrepresented in public health centres (Parmanne et al. 2016: 25–26). Young and early-career doctors also work on call more often than their senior colleagues (Parmanne et al. 2016: 30). Moreover, doctors on call must often work at times that are inconvenient for young women dealing with family responsibilities (Kiianmaa 2012). The two foci allow us to tackle some of the most salient structural inequalities in the medical profession related to gender and age. Our focus on discursive practice allows us to argue that doctors' difficulty (and reluctance) to criticise these inequalities is an aspect of the hegemony of a specific, masculine understanding of medicine that tends to treat the difficulties faced by young and female doctors as inevitable and normal features of a demanding

profession. We conclude by considering whether career systems that are built on such cultural ‘contracts’ are socially sustainable in the long haul.

### **A ‘feminised’ and numerically expanding profession**

The male domination in the Finnish medical field may appear paradoxical since the feminisation of medicine (in numerical terms) has such a long history in Finland. The proportion of female doctors increased in Finland earlier than in any other Nordic or Anglo-American country (Riska and Wegar 1993; Riska 2001), and it keeps increasing. Although at the beginning of the 20<sup>th</sup> century practically all physicians in Finland were men, in 2016 sixty per cent of Finnish physicians were women (Parmanne et al. 2016: 8).

Gender segregation, nevertheless, is a persistent feature of the Finnish medical profession. In 1964, Haavio-Mannila noted that, while there was an equal proportion of men and women in most types of medical work, men much more often combined their work with private practice. She explained the figures by noting that most women doctors held double roles as doctors and as mothers and wives (Haavio-Mannila 1964: 12–14). In the early 1990s, Riska and Wegar (1993: 84) observed that female doctors were most often found in organisational settings characterised by a bureaucratic medical practice, relatively low degree of occupational autonomy, high degree of routinisation, low salary and low professional status compared to their male colleagues. To the authors, these divisions of labour were expressions of institutionalised ‘glass ceilings’ that hinder women’s career advancement in the Finnish medical field (Riska and Wegar 1993). In the 2000s, the career advancement opportunities available to female doctors increased in Finland, causing a growing number of female physicians to hold administration, research and teaching positions. In particular, over the past two decades, the proportion of women serving as chief physicians has grown substantially (Parmanne et al. 2016: 27–29). Yet, the proportion of women among these decision-makers still does not equal the proportion of female practitioners.

In Finland, where medical education has constantly expanded since the Finnish government has sought to encourage more people to become doctors, female doctors are overrepresented in younger cohorts (Parmanne et al. 2016: 6–9). Some of the difficulties faced by female doctors regarding job content and hierarchical position may be more related to their early career stage and the patterns of practice associated with this stage than to their gender. In Finland, young doctors (ie those under 35 years of age) are overrepresented in public health centres (Parmanne et al. 2016: 26), making them more likely to experience precarious working conditions. On average, doctors in working at public health centres report more problems, such as poorly functioning IT machinery, constant time pressure and lack of collegial support, than doctors at other workplaces, such as public hospitals and private clinics (Finnish Medical Association 2016).

Young doctors must work at public health centres; training for all medical specialties requires service at a health centre for nine months. Due to such compulsory elements it is not surprising that young doctors tend to report less autonomy at work than their older colleagues (Finnish Medical Association 2016). Young and female doctors also work while ill more frequently but take more sick leave as well; in 2015, 71 per cent of under 35-year-old female doctors took sick leave during the past 12 months, while only 39 per cent of 55–64-year-old male doctors took sick leave (Finnish Medical Association 2016). Some inequalities are more strongly related to gender than to age; for instance, female doctors tend to have more work overload and a higher risk of burnout than men, regardless of their age and workplace (Finnish Medical Association 2016).

The inequalities affecting young and female doctors described above are relatively well-known and have been reported in previous research and, recently, Finnish media (Järvi 2011; Paatero 2018; Piirainen 2018). Critical media coverage might signify a small disjunction within the hegemonic culture of the medical profession. In particular, the Finnish association representing young doctors is increasingly critical of phenomena linked to gender- and age-related inequalities in medical professions (eg Paatero 2018; Piirainen 2018). Despite this criticism, the legitimacy and acceptability

of divisions of labour seem to be maintained in the Finnish medical field. Young doctors in health centres and hospitals still report surprisingly low—and similar—levels of dissatisfaction with their work. In a 2013 survey (Sumanen et al. 2015: 45–48), only seven per cent of recently graduated doctors working at health centres and hospitals reported being somewhat or extremely dissatisfied in their current jobs. The majority of respondents (average age: 34) considered their current jobs to be their first choice and expected to hold similar jobs in 2025. Interestingly, the respondents' preferences were significantly gendered; women much more often preferred working at health centres (20% of women vs. 11% of men). To an extent, doctors' personal preferences thus aligned with the existing career systems in Finnish medicine.

Based on the observations made earlier, one can speculate that many young doctors learn to adjust their individual expectations to match the options that are socially and practically available to them. For instance, health centres have much less need for on-call work than hospitals (Parmanne et al. 2016: 30). One could speculate that, since women perform a larger share of domestic responsibilities (eg childcare and housework) compared to men (Kiianmaa 2012), many young women 'choose' to pursue a career in health centres rather than in hospitals. This apparent alignment between individual expectations and existing career systems is an important source of social legitimacy for any liberal profession; the profession maintains a division of labour based on the free will and personal choice of individual actors rather than open, explicit and unjust exclusion of certain people (eg Olakivi 2018).

Previous commentators (Sumanen et al. 2015: 20) have also identified a culture of individual endurance in the Finnish medical field. In line with Davies' (1996) discussion of medicine as a 'male' profession, ideals of individual endurance can be interpreted as expressions of hegemonic masculinity. The ethos of individual endurance highlights and values doctors' ability to individually manage the difficulties they face. Consequently, the masculine ethos can individualise and privatise gendered and age-related problems in professions that might otherwise receive political and transformative attention. A doctor who talks about problems in her work, including precarious work

environments or lack of collegial support, is liable to be stigmatised as an uncommitted or incompetent doctor who lacks the (masculine) abilities of self-management and endurance. Against this cultural background, it is not surprising that the challenges and obstacles faced by young and female doctors are not always explicitly articulated as public concerns that require intervention from professional agencies, not even by young and female doctors themselves.

### **Theoretical perspective on inequality regimes in medicine**

In line with Acker (2006), gendered and age-related inequalities in the medical profession can be examined as elements of ‘inequality regimes’, that is, of the social processes and practices that create, make sense of and legitimate inequalities in work. Two dimensions of inequality regimes are particularly relevant to our study: the *visibility* and *legitimacy* of inequalities (Acker 2006). Inequalities are not always publicly visible and recognised as matters that require collective intervention. As Berbrier and Pruett (2006: 261) note, ‘[a]ny “inequality” may be recognized as real and existing, but still taken for granted as the inevitable, normal, and/or functional means of distributing wealth, power, prestige, safety, and security, or anything else considered valuable’. Additionally, according to Acker (2006), societal change is more likely for social inequalities with high visibility and low legitimacy and less likely for inequalities with low visibility and high legitimacy.

From the cultural and discursive perspective we adopt in this chapter, the visibility and legitimacy of inequalities depend on the meanings that doctors collectively assign to the problems they—or some of them—face in their work (eg Harris 2006). By drawing on collectively recognisable values, narratives and identities as building blocks and resources of discursive practice, doctors can mobilise different interpretations of such problems (see Berbrier and Pruett 2006; Harris 2006). Some interpretations help doctors visualise illegitimate inequalities in their—or their colleagues'—work. Others construct inequalities as legitimate, natural and inevitable features of a demanding profession or diminish the importance of collective intervention by highlighting the importance of doctors’



individual endurance. To doctors, some interpretations can be more affectively appealing than others, depending on how the profession articulates its collective values and desirable ‘subject positions, or the ways in which professionals should conduct themselves’ (Fournier 1999: 285). In a culture that values all actors’ private responsibility and individual endurance, doctors’ ability to demonstrate such qualities can amplify their sense of dignity and self-respect and, consequently, ‘make their work tolerable, or even make it glorious to themselves and others’ (Hughes 1984: 342). This can help doctors legitimate and accept environments that might otherwise be difficult to bear morally or materially.

## **Methods and materials**

Our empirical study involves interviews with 38 doctors in Finland. Half of the interviewees were recently graduated doctors with an average age of 34 years, and the other half were doctors with at least 20 years of clinical experience who were 60 years of age or older. Eighteen of the interviewees were women. We recruited the interviewees via the Finnish Medical Association, mostly by random sampling from the membership register. The interviewees worked at public health centres, public hospitals and private clinics in two large hospital districts in Southern Finland. We mainly conducted the interviews at the interviewees’ workplaces. The interviews were audio-recorded and transcribed verbatim. The extracts in this chapter were translated by the authors. In the extracts, square brackets indicate removed passages or the authors’ additions.

Gender and age were not explicitly topicalized in the interview scheme apart from a question about potential differences in the ‘work orientations’ of doctors ‘at different career stages, at hospitals and health centres’. Other questions and themes included doctors’ relations with their colleagues, autonomy at work and work with patients.

In this chapter, we analyse selected parts of the data from a specific gender perspective. First, we analyse extracts in which doctors discuss the pressures and responsibilities of on-call work. Second,

we analyse extracts in which doctors discuss the pressures and constraints of work at health centres. Our analysis demonstrates how the (mostly male but also female) doctors in our interviews were able to downplay the visibility of gendered and age-related injustice, to frame the position of young and female doctors as unavoidable, acceptable and tolerable and to articulate the problems they face as individual, private and apolitical problems that do not require political reform (at least not from *within* the profession). We examine the interviews as examples of discursive practice in which the participants draw on cultural and discursive resources (eg values, narratives and identities) to offer collectively recognisable interpretations of their work while maintaining impressions of themselves as good doctors. Although our analysis is based on research interviews, doctors can—or must—draw upon similar (albeit not always the same) cultural and discursive resources in other contexts, including interactions with their colleagues.

### **Working on call – objective obstacles and ‘personal preferences’**

Young and early-career doctors who worked in hospitals often described working on call as a key source of stress (also, Wrede et al. 2017). Compared to work at health centres, hospital work involves more on-call duties, the majority of which are performed by early-career doctors. In addition to causing stress, on-call duties can create gendered inequalities and divisions of labour in the medical profession. Many young women have a ‘second shift’ at home, which may be difficult to manage with the often inconvenient hours of on-call work.

In the interviews, we asked a question about on-call work in the form of a narrative vignette (see Hughes and Huby 2012):

*You are working in a unit in which on-call work is an essential part of the functions. Doctors’ collective bargaining contract defines on-call work as a duty of doctors. Because working on call is a duty of doctors, on-call shifts must be divided equally and justly, which is also the view of the [Finnish] Medical Association. Some colleagues in your unit have reasonable causes for*

*not wanting to work on call. This situation creates problems for the division of on-call shifts in the unit. What do you think about the situation?*

We asked the interviewees to discuss the vignette from different perspectives. Literally, the vignette invited them to not only elaborate on reasonable causes for not wanting to work on call but also define 'equal' and 'just' distribution of on-call work. According to a cultural ideal often invoked in the interviews, equal and just division of on-call work means *numerical* equality (ie all doctors in a unit have an equal share of on-call shifts). This ideal, however, was not blindly supported by most participants; most acknowledged some reasonable causes for not wanting to work on call. A 37-year-old male participant from a private clinic reflects upon these causes:

*PARTICIPANT 2: If the reasonable cause is that there is a colleague who has bipolar disorder and staying awake at nights makes her/him<sup>2</sup> mentally unbalanced, then s/he does not work on call. We—other colleagues—take care of it and it's understandable. [...] Then, if there is someone who has young children and who just wants to be at home with them and has selected a field [of medicine] that includes working on call, then no-can-do. Then you must work on call. Or you must change your field or workplace. I don't think these are very complex issues in the end. People know that it is part of their job when they select a field in which people work on call. If it doesn't fit your life situation, you must make your own arrangements. For instance, you can work somewhere else when the children are small.*

In the interviews, many participants clearly distinguished between cases in which one is objectively unable to work on call and one simply prefers not to for understandable but illegitimate reasons. Participant 2 constructs this kind of distinction between a doctor with a medical condition and one who has young children. In this line of reasoning, having young children may result in (gendered) divisions of labour in the medical profession that are natural and legitimate because they depend on doctors' private choices, that is, their allegedly private choices to, first, , have children and, second, 'be at home with them'.

To some interviewees, however, the above simple and, one might argue, gender-blind way of viewing the demands of on-call work did not seem entirely appropriate. These interviewees gave more nuanced answers to the vignette and more reflexive impressions of themselves but, oftentimes, came to the same conclusion as Participant 2. In the following extract, a 63-year-old male doctor who primarily fulfils an administrative role elaborates on the vignette from multiple perspectives:

*PARTICIPANT 14: There are pretty clear rules. There is age and...I mean the age after which working on call decreases or ends according to the rules. But, of course, in real life [...] there are always those who complain, 'why so much on-call work' and so on. But I don't know. Then it's part of the human resource management skills of the leader to build the kind of unit in which people participate in on-call work in decent ways but in which different life situations are also taken into consideration. There can, of course, be like, for instance, a woman doctor who has recently become a single mother of young children or something like that. I assume that people will understand it [ie not working on call] then. But it is a question of leadership, how to take care of it. In general, doctors' willingness to work on call [päivystyshalukkuus in Finnish] has decreased. Back in the old days, it was somehow so natural that one needed to work on call because one needed to work on call.*

In the extract, the participant begins by highlighting that there are 'pretty clear rules' but then moves on to make exceptions to these rules because, in 'real life', there are always those who complain about working on call. Instead of describing clear rules, he ends up highlighting the importance of reflexive leadership and consideration of different life situations as a way of solving potential problems. The example of 'a woman doctor who has recently become a single mother of small children' demonstrates a degree of reflexivity and awareness of gendered issues. This may be related to the contemporary demand for doctors, particularly those in supervisory positions, to demonstrate (a degree of) gender awareness in the medical profession and to avoid impressions of exclusion and inequality. The example of a recent single mother is, however, clearly marked as a special case that

‘people will understand’. Evidently, family responsibilities are not normally understandable and legitimate reasons for not working on call. Finally, at the end of the extract, after demonstrating understanding and reflexivity, the participant invokes a novel theme: contemporary doctors’ decreasing willingness to work on call.

Young doctors’ (alleged) unwillingness to work on call was a common topic in our interviews with senior doctors. Occasionally, the interviewed doctors demonstrated a degree of sympathy towards such unwillingness and its gendered dimensions. Participant 14, for instance, commented on some women’s unwillingness to work on call: ‘If you have children at home, then you have some worries going through your mind about those things [i.e. the children] [. . .] and you are away from home, then the desirability of working on call is not that great’. In this line of reasoning, unwillingness to work on call was psychologically understandable but, ultimately, not a professionally legitimate reason to not work on call (or even to reduce the amount of on-call work). Ultimately, the burdens of on-call work were private problems of female doctors’ (and their families), not issues that would require collective action. Regardless of the (superficial) reflexivity and understanding that these participants tried to demonstrate (in their talk), when it came to actual calls for transformative action, gender-blind work arrangements remained untouched.

Finally, not all doctors demonstrated understanding of young doctors’ (allegedly) decreasing willingness to work on call. For many interviewees, this unwillingness signified young doctors’ corrupt interests, lack of professional devotion or inability to manage their private lives (also, Wrede et al. 2017). In the following account, a 61-year-old male doctor from a private clinic considers having young children to not be a reason to avoid working on call:

*PARTICIPANT 37: In my youth, when I had just graduated, it [ie having young children] wasn’t a reason at all for not working on call. People worked on call even when they had young children. Childcare was just arranged in one way or another. It’s a contemporary thing, that they [ie young doctors] use it as a reason. It is difficult for me to understand, since I don’t have*

*children, and if I had, they'd be adults already and I'd have lived through the time when childcare was arranged in such a way that people were able to work on call. I find it difficult to place myself in the position of these present-day fathers and mothers and to view things from their perspective.*

In the above extract, the participant demonstrates a seemingly genuine inability to understand the contemporary position of young doctors with children. In his youth, childcare was arranged, although the actors who arranged it remain unspecified or taken for granted in the above extract. Overall, his account casts a shadow of doubt over young doctors' abilities, ethics and interests, implying they 'use' childcare as a reason, that is, an excuse, for not working on call. This reason, according to Participant 37, is not understandable or legitimate. At the end of the extract, the participant highlights his gender-neutral—or gender-blind—perspective on the issue at stake, mentioning both male and female doctors who use childcare as a reason to avoid working on call. The gendered aspect of the topic is thus tacitly denied.

In this discursive context, it is hardly surprising that young mothers find it difficult to criticise the medical system, which reproduces a culture of hegemonic masculinity. Such a criticism is liable to be misinterpreted by senior (and male) doctors. Consequently, many young mothers end up working in seemingly less masculine contexts, such as public health centres.

### **The health centre as a constraining work environment**

In comparison to hospitals, balancing family and work can be easier while working at health centres, at least in part due to the more limited amount of on-call work. Compared to hospitals, public health centres indeed employ more women and early-career doctors. In this section, we examine how young doctors working at public health centres described their work, including the problems they encountered, in the interviews. In line with previous research, many young doctors described public health centres as professionally constraining and difficult work environments (also, Wrede et al.

2017). In line with previous research, they were also willing to accept personal responsibility for the problems they faced. In the following extract, a 32-year-old male doctor describes public health centres as workplaces in which doctors have few resources and little support:

*INTERVIEWER: Have you noticed any differences between doctors' work orientations, between, for instance, doctors at different career stages, in hospitals, health centres and private practices, or between women and men? And if so, what kinds of differences? [...]*

*PARTICIPANT 24: I feel that young doctors take their work more personally, which usually leads to a greater mental burden. [...] A young doctor is usually very careful, very cautious and very thorough. At least that's what I would argue, on average. I am not necessarily saying that this is always the case. But what it leads to is that every patient is potentially dying right now and you must concern yourself with a whole lot of things. [...] I cannot say there are any significant overall differences between male and female colleagues. [...] But then if you think about hospitals versus health centres, then only a few have liked health centres. Usually it's because of the feeling of insecurity that is much more common in here [i.e. health centres], the lack of resources, that you have a constant hurry, that you do not necessarily get the kind of support that you usually get in special health care, at the lunch table for instance. We do not necessarily have time to eat lunch in here. So, young doctors are normally afraid of health centres because you are alone in there. My own view is that, now, when I have practically only worked in well-functioning health centres, in my opinion it has been amazing and the only burdens there are have been my own constructions. It's me who decides how many patients I meet, and it is me who decides how carefully I examine them.*

In the extract, the participant—together with the interviewer—draws on different collectively recognisable interpretations of the position of young doctors at public health centres. On the one hand, he highlights the objective difficulties of his work at a public health centre (i.e. the lack of resources and support). On the other hand, he highlights his own and other young doctors' individual agency:

young doctors tend to be mentally overburdened because they are deliberate and devoted and tend to take their work personally; that is, not because of the external and objective pressures they face, but because of their internal and subjective orientations. The extract thus exemplifies the ambivalent position of young and early career doctors at public health centres. On the one hand, young doctors have well-established cultural and discursive resources with which they can mobilise critical interpretations of their position and work at public health centres. On the other hand, the masculine culture of individual endurance can encourage young doctors to emphasise their own agency and responsibility for managing the problems they face—also as a source of pride and prestige. Ultimately, young doctors can end up reproducing a culture that privatises and undermines these problems as their own constructions. Participant 24's ability to bring up problems in his work while simultaneously assuring his audience—and perhaps himself—of the completely manageable and tolerable nature of these problems (at least in the particularised context of 'well-functioning health centres') is striking. Evidently, a good way for young doctors to raise awareness of problems in their work is, paradoxically, to highlight that these problems are not 'real' problems at all—at least not for themselves. Otherwise, young doctors risk losing their credibility as competent, trustworthy and self-managing professionals who can manage demanding work. In such a discursive context, presenting substantial criticism of the organisation of work can be extremely difficult. When voicing out criticism, victim blaming is a constant threat.

In the following extract, a 30-year-old woman doctor describes problems in her work at a health centre, including a lack of resources. Like Participant 24, she highlights the importance of self-management:

*INTERVIEWER: Have you noticed any differences between doctors' work orientations, between, for instance, doctors at different career stages, in hospitals, health centre and private practices, or between women and men?*



*PARTICIPANT 15: Well, I guess differences are inevitable if you think about the people at our workplace, for instance. Of course, young doctors .... [...] Also, when I had just graduated, the amount of work felt, how should I put it, somehow more overwhelming. Everything is, of course, more difficult [when you have just graduated].... You must concern yourself with everything. And you don't have the kind of touch that you get from experience. [...] There can be a kind of insecurity in respect to your own skills. And then, on the other hand, the way you manage with this insecurity. [...] Personally, I already belong to specialising [doctors] at this stage [of my career], so it kind of varies day by day. [...] It depends on the number of doctors in the roster and a bit on the season, how burdensome the work is. In the wintertime, for instance, when lot of people have the flu and a lot of doctors are away and their kids are sick, and the patients have the same thing, then it can be quite burdensome and tiring. And, when I have talked to my colleagues at this same career stage, it does come up occasionally, that you might want to do something else. Sometimes you think about it, half seriously, that, gosh, I'm gonna switch to another trade and do something completely different.*

Like Participant 24, Participant 15 describes her work as potentially burdensome and relates this burden to a particular career stage; she claims that young doctors *inevitably* face more difficulties at work. Like Participant 24, Participant 15 tries to assure her audience—and perhaps herself—that these difficulties no longer concern her since she has learnt to manage her work and insecurity. In this way, she can distance herself from the professionally precarious (and stigmatised) identity of a young doctor. Significantly, after adopting the identity of a specialising doctor in the above extract, she seems to receive a whole new right to complain. As a *young* doctor, she needed to concern herself with everything and learn how to manage her work. As a *specialising* doctor, she can complain that her work is burdensome and tiring and ask for more interesting tasks beyond caring for patients with the flu in a precarious context in which doctors are overburdened with private responsibilities (ie

childcare). As a *specialising* doctor, she can even consider resigning from her profession. Later in the interview, she expresses a fear of stagnation:

*PARTICIPANT 15: Specialisation is, of course, nice. But, in a sense, when you have completed your specialisation, then it's not so easy to get anywhere, to work periods in hospitals, train yourself, try something different, acquire knowledge. They would like to keep those specialised doctors stuck here a little bit, stuck in a health centre. At least, people have had that kind of experiences.*

The participant does not name any identifiable actor at a health centre or hospital that is keeping her at the health centre. By referring to 'people' in the last sentence, however, she implies that other doctors also experience the problems she describes.

The above extracts introduce some of the dilemmas associated with the cultural situation of young doctors working at public health centres. First, among young doctors, working at a health centre is recognised as less prestigious and more precarious than working in a hospital. Second, the identity of a young doctor is easily stigmatised in the medical field. In the interviews, early-career doctors often distanced themselves from the stigmatised identity of a young doctor by highlighting their age or career stage as a positive sign of devotion or precision, even at the expense of their own wellbeing, or by highlighting their ability to manage themselves and their insecurities. In a masculine culture of individual endurance, these professional self-presentations are, evidently, sources of (self-)respect and prestige. For young doctors, they are understandable—and perhaps necessary—discursive strategies. Simultaneously, the constant emphasis on individual endurance can hinder young doctors from critiquing the problems they face. Instead of presenting critique, a good doctor presents self-management. In addition, for many young doctors, it is difficult to name professional or political actors that are responsible for the problems they face. The specific reasons for career stagnation, for instance, are also not always easy to identify.

## **Discussion and conclusions**

Young and female doctors in Finland face multiple constraints and challenges in their work and careers (also, Wrede et al. 2017). However, our analysis shows that doctors' discursive practice does not always recognise these constraints and challenges as markers of illegitimate, gendered or age-related inequality that self-evidently requires collective intervention. Instead of attributing the difficulties faced by many young and female doctors to the illegitimate structures of a masculine and middle-class profession, doctors' discursive practice tends to construct these difficulties as natural and inevitable features of a demanding profession. Furthermore, doctors' discursive practice tends to highlight people's private and individual responsibility for overcoming the difficulties they face. To many young doctors, individual responsibility, endurance and self-management are key sources of prestige and self-respect and ways to avoid the stigma associated with young doctors.

For individual doctors, highlighting individual endurance is understandable in a discursive context that values such endurance. At the same time, we observe tensions that are relevant to the future of career systems in the Finnish medical field. The social sustainability of a career system that supports the dominant 'male' culture of medical professions is problematic for all doctors who are unable or unwilling to conform to traditional masculine norms, such as freedom from family responsibilities. Furthermore, in the current career system, work at health centres is not highly regarded, and remaining there in the long term is commonly interpreted as career stagnation. This is a situation predominantly faced by female doctors. In a culture that highlights all actors' private responsibility, these women may also lack the resources to mobilise critiques over their slower career progress. In the discursive practice of a 'male' profession, these women are not necessarily considered to be unjustly excluded from higher-ranked and prestigious jobs. Rather than illegitimate results of objective obstacles, their career paths can be considered legitimate results of their personal interests, preferences or lifestyle choices, such as their 'unwillingness' to work inconvenient hours. Men, however, tend to be able to make the choice to have a family without negatively impacting their career

advancement. A culture that views family responsibilities as private business does not recognise this discrepancy as a problem that requires a collective response.

The traditional ideals of the ‘male’ profession of medicine seem to persist. Currently, however, traditional masculine ideals may not be accepted without negotiation and potential counter-arguments. In a recent survey, the ability to balance work and family was revealed to be one of the most important values of Finnish doctors, predominantly those who are young and female (Finnish Medical Association 2018). The way the interviewees discussed dilemmas associated with on-call work, moreover, demonstrated a lack of consensus within the medical profession regarding work–family balance (see Wrede et al. 2017). While the traditional expectations of the ‘male’ profession of medicine are still powerful, it seems that these expectations can no longer be endorsed without at least superficial demonstrations of reflexivity, without considering alternative ideals, and without potential controversies among doctors in Finland. Also, the disadvantaged position of young doctors in Finland has recently gained increasing media coverage. Clearly, actors in the Finnish medical field must start discussing these issues in greater depth.

Based on our analysis, we can envision alternative outcomes concerning the social sustainability of career systems within the medical field in Finland. First, career systems in the medical field can be made more diverse and inclusive in terms of accommodating diverse family arrangements and combining work at hospitals and health centres. Besides transformation of the structural organisation of work, this change will require evolution of the cultural ideals and expectations of the medical profession. It is likely that some (male) actors who have benefited from the masculine organisation and culture of the medical profession will oppose these changes. Second, the divisions of labour in the medical profession can remain gendered, the career systems can remain exclusive and balancing family and work can remain difficult. In this case, a crucial question is, how the medical profession maintains the social legitimacy of these divisions of labour and career systems among its members? For how long young and female doctors can remain satisfied and tolerate the difficulties they face in

their work and careers? Currently, this legitimacy, satisfaction and tolerance seem somewhat strong, but there is underlying discontent. Whether—or perhaps when—this discontent will result in political action remains to be seen.

## References

Acker J (1990) 'Hierarchies, jobs, bodies: A theory of gendered organizations' 4 *Gender & society* 139, 158.

Acker J (2006) 'Inequality regimes: Gender, class, and race in organizations' 20 *Gender & society* 441, 464.

Berbrier M and Pruett E (2006) 'When is inequality a problem? Victim contests, injustice frames, and the case of the office of gay, lesbian, and bisexual student support services at Indiana University' 35 *Journal of contemporary ethnography* 257, 284.

Davies C (1996) 'The sociology of professions and the profession of gender' 30 *Sociology* 661, 678.

Finnish Medical Association 2016, Lääkäriin työolot ja terveys 2015 Kyselytutkimuksen tuloksia, accessed 3 April 2018,

<[https://www.laakariliitto.fi/site/assets/files/1266/l\\_k\\_rin\\_ty\\_olot\\_ja\\_terveys\\_2015\\_tuloksia.pdf](https://www.laakariliitto.fi/site/assets/files/1266/l_k_rin_ty_olot_ja_terveys_2015_tuloksia.pdf)>.

Finnish Medical Association 2018, Unpublished survey data.

Fournier V (1999) 'The appeal to 'professionalism' as a disciplinary mechanism' 47 *The Sociological Review* 280, 307.

Järvi U (2011) 'Naislääkäreillä kivinen tie professoreiksi' 66 *Lääkärilehti* 2228, 2231.

Haavio-Mannila E (1964) *Lääkärit tutkittavina* (Helsinki, University of Helsinki).

- Harris S R (2006) 'Social constructionism and social inequality: An introduction to a special issue of JCE' 35 Journal of Contemporary Ethnography 223, 235.
- Hughes EC (1984) Sociological Eye. Selected Papers (New Brunswick, Transaction Books).
- Hughes R and Huby M (2012) 'The construction and interpretation of vignettes in social research' 11 Social Work and Social Sciences Review 36, 51.
- Kiianmaa N (2012) Tasa-arvobarometri 2012 (Helsinki, Ministry of Social Affairs and Health).
- Olakivi A (2018) The relational construction of occupational agency: Performing professional and enterprising selves in diversifying care work (Helsinki, University of Helsinki).
- Paatero J (2018) 'Ettei homma tökkisi', Nuori Lääkäri, March, accessed 18 September 2018, <<https://www.nly.fi/artikkeli/ettei-homma-tokkisi>>.
- Parmanne P, Ruskoaho J and Vänskä J (2016) Lääkärit Suomessa. Tilastotietoja lääkäreistä ja terveydenhuollosta 2016 (Helsinki, Finnish Medical Association).
- Piirainen J (2018) 'Kiusaamista, nöyryyttämistä, solvaamista ja savustamista – nuoret lääkärit kertovat alalla vuosia jatkuneesta asiattomasta käytöksestä', YLE, 6 March, accessed 6 March 2018, <<https://yle.fi/uutiset/3-10102659>>.
- Riska E (2001) 'Towards gender balance: but will women physicians have an impact on medicine?' 52 Social Science & Medicine 179, 187.
- Riska E (2010) 'Health professions and occupations' in WC Cockerham (ed), The New Blackwell Companion to Medical Sociology. (West Sussex, John Wiley & Sons).
- Riska E and Wegar K (1993) 'Women Physicians' in E Riska and K Wegar (eds), Gender, work, and medicine: women and the medical division of labour (London, Sage Publications).

Sumanen M, Vänskä J, Heikkilä T, Hyppölä H, Halila H, Kujala S, Kosunen E, Virjo I, Mattila K (2015) Lääkäri 2013. Kyselytutkimus vuosina 2002–2011 valmistuneille lääkäreille (Helsinki, Ministry of Social Affairs and Health).

Wrede S, Olakivi A, Fischer N, Sigfrids, A (2017). Autonomia ja ammatillisuus käytännön lääkäreiden näkökulmasta (Helsinki, Finnish Medical Association).

## BIOs

**Antero Olakivi** is a post-doctoral researcher at the University of Helsinki in the Centre of Excellence in Research on Ageing and Care. His sociological PhD dissertation, *The Relational Construction of Occupational Agency: Performing Professional and Enterprising Selves in Diversifying Care Work* (University of Helsinki, 2018), examined the construction of ethnic and migration-based inequalities in old-age care work in Finland. He has published articles in journals such as *Sociology of Health and Illness* and *Journal of Professions and Organization*. He is a member of the editorial team of the journal *Professions and Professionalism*.

**Sirpa Wrede** is a Senior Lecturer in Sociology at the University of Helsinki and Vice-Director and Team Leader at the Centre of Excellence in Research on Ageing and Care. She has carried out research on professions and professionalism since the mid-1990s and has led several related projects funded by Academy of Finland. She has published articles in journals such as *Sociology of Health and Illness* and *Social Science and Medicine*. She holds the title of Docent in Sociology at University of Helsinki. This chapter is based on her ongoing research collaboration with the Finnish Medical Association, which began in 2015.

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<sup>2</sup> In Finnish, pronouns are gender-neutral.